SECTION 3

LEGAL AND ADMINISTRATIVE INFORMATION

SECTION 3-LEGAL AND ADMINISTRATIVE INFORMATION

WHEN COVERAGE ENDS

Your coverage under the Citigroup Medical Plan, Dental Plan, and Vision Care Plan will terminate automatically on the earliest of the following dates:

- The date the Plan terminates;
- The last day for which the necessary contributions are made;
- Midnight of the last day of the month in which your employment terminates, you retire, you die, or you otherwise cease to be eligible for coverage;
- The date benefits paid on behalf of a participant equal the lifetime maximum benefit under the Plan (coverage for eligible dependents who haven't reached their lifetime maximum won't be affected); or
- Midnight of the last day of employment if your termination is due to gross misconduct.

Basic Life insurance coverage and coverage under the Health Care Spending Account end on the date your employment is terminated. Optional GUL insurance coverage ends on the last day of the month in which your employment terminates.

Your eligible dependent's coverage automatically will terminate on the earliest of the following dates:

- Midnight of the last day of the month in which your coverage terminates; an exception is your death in which case coverage will continue for six months;
- The date you elect to terminate your eligible dependent's coverage;
- The last day for which the necessary contributions are made;
- The date the eligible dependent ceases to be eligible for coverage; coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age or is no longer a full-time student (although coverage under some HMOs may end at the end of the month in which the child reaches the maximum age); coverage will remain in effect through the end of the month in which the child gets married or obtains a full-time job;
- The date the eligible dependent is covered as an employee under the Plan;
- The date the eligible dependent is covered as the dependent of another employee under the Plan;
- The date the eligible dependent enters the armed forces of any country or international organization; or
- The date the dependent is no longer eligible for coverage under a Qualified Medical Child Support Order.

You and your eligible covered dependents may be able to continue coverage under COBRA. See "COBRA" beginning on page 81.

COVERAGE FOR SURVIVING DEPENDENTS

When an active employee dies, if the surviving spouse and/or dependent children were enrolled in active coverage at the time of the employee's death, then these covered individuals will be eligible to continue health care coverage for six months.

If the employee wasn't eligible for retiree health care coverage at the time of death: Medical and dental coverage will continue for the covered individuals for six months at no cost. After the six-month period, they'll be eligible to continue coverage through COBRA. The six-month period of continued coverage is considered part of the COBRA period. See "COBRA" beginning on page 81.

If the employee was eligible for retiree health care coverage at the time of death: Covered individuals will be eligible for either retiree health care coverage or COBRA coverage at the end of this six-month period. Retiree health care coverage will be provided on the same terms as coverage provided to a retired employee.

COVERAGE IF YOU BECOME DISABLED

If you're disabled, you and your eligible dependents may continue medical, dental, and vision care coverage and participate in the Health Care Spending Account for up to 13 weeks, as long as you make the active employee contributions.

If you're totally disabled, coverage will continue as follows:

Medical coverage will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. After that, you may continue medical coverage by making the same contributions as active employees, based on your length of service as shown on page 74. (After 52 weeks of disability, your employment will be terminated.)

LENGTH OF RECOGNIZED CITIGROUP SERVICE AT THE TIME YOUR LTD IS APPROVED	MEDICAL CONTINUATION PERIOD AFTER WEEK 52 (THE TERMINATION OF YOUR EMPLOYMENT)
Less than 2 years	6 months
2 years to less than 5 years	Equal to your length of service
5 years or more	As long as you're disabled or haven't reached the maximum age limit to receive LTD benefits

The disability administrator will medically manage your disability if you're a totally disabled employee who's been denied LTD due to a pre-existing condition, didn't enroll in LTD coverage, or who's reached the maximum benefit under the two-year limitation rule.

If the administrator determines that you're totally disabled, medical coverage will continue at the active employee rate for the lesser of a length of time based on your service (see chart above) or the length of your disability.

At the end of the medical continuation period shown above, you may continue coverage through COBRA. The above continuation period is considered part of the COBRA period.

If you're enrolled in a non-HMO medical plan, once you become disabled for more than 29 months, Medicare will become your primary medical coverage while benefits under the Citigroup plan become secondary.

Dental coverage will continue for 52 weeks (including the 13-week period of STD) as long as you pay the active employee contributions. You then may continue coverage under COBRA.

Vision care coverage will continue for the 13-week period of STD as long as you pay the active employee contributions. You may then continue coverage through Davis Vision.

Health Care Spending Account participation will continue for the 13-week period of STD as long as you pay the active employee contributions. You may then continue coverage under COBRA. You'll have until June 30 of the following calendar year to submit claims.

Dependent Care Spending Account participation ends on your first day of STD. When you return to work from your approved disability, you can re-enroll. You can incur expenses though the end of the calendar year and will have until June 30 of the following calendar year to submit claims.

Transportation Reimbursement Incentive Program (TRIP) coverage ends on your first day of STD. When you return to work from your approved disability, you can re-enroll. You can be reimbursed for expenses incurred prior to your first day of STD. You must file claims for expenses within 12 months of the date in which the expense was incurred.

CONTINUING COVERAGE DURING AN FMLA LEAVE

The federal Family and Medical Leave Act (FMLA) entitles eligible employees to take a leave each year for serious illness; the birth or adoption of a child; or to care for a spouse, child, or parent who has a serious health condition.

If you're eligible for FMLA, you may take up to a total of 13 weeks of leave each year, except where state law mandates differently.

If you take an unpaid leave of absence that qualifies under the FMLA, you may continue medical, dental, and vision coverage for yourself and your dependents and continue participating in the HCSA as long as you continue to contribute your share of the cost of coverage during the leave. Your monthly contributions during a leave are made on an after-tax basis. You'll be billed directly.

If you lose any coverage during an FMLA leave because you didn't make the required contributions, you may re-enroll when you return from your leave. Your coverage will start again on the first day after you return to work and pay the required contributions.

If you don't return to work at the end of your FMLA leave, you'll be entitled to enroll in COBRA to continue your medical, dental, vision, and HCSA coverage.

If your employment is terminated while you're on an FMLA leave, you also may be eligible to continue your coverage under COBRA.

If you continue coverage through COBRA during an FMLA leave, you'll have access to the entire amount of your HCSA annual election, less any reimbursements you've received. If you stop contributing, your participation in the HCSA will terminate while you're on an FMLA leave. In that case, you may not be reimbursed for any health care expenses you incur after your coverage was terminated.

If your HCSA participation is terminated during your leave, your HCSA contributions will begin again if you return to work during the same year in which your leave began. You can choose to resume contributions at the same level in effect before your FMLA leave or elect to increase your contribution level to make up for the contributions you missed during your leave.

If you resume your prior contribution level, then the amount available for reimbursement for the year will be reduced by the contributions you missed during the leave.

Regardless of whether you choose to resume your prior contribution level or to make up missed contributions, you can't use your HCSA for expenses incurred during the period in which you didn't participate.

COVERAGE IF YOU TAKE A LEAVE OF ABSENCE

If you're on an approved leave of absence, call the Benefits Service Center, as instructed on page 4, about your rights to continue medical, dental, vision, and/or HCSA coverage.

CONTINUING COVERAGE DURING A MILITARY LEAVE

As of the printing of Citigroup's 2006 enrollment materials, Citigroup's Paid Military Leave of Absence Policy was extended through March 10, 2006. If this policy is extended beyond that date, you'll have the right to continue your health and welfare benefits in accordance with the terms and conditions of the policy.

For the latest copy of the policy, visit Citigroup.net. From the home page, use the search function and enter "military leave." Then click on the most current policy.

If the Paid Military Leave of Absence Policy isn't extended through the end of 2006, you're still entitled to continue your health benefit coverage in accordance with the terms and conditions of the applicable Plans.

If you take a military leave of absence — whether for active duty or for training — you're entitled to continue your medical, dental, vision, and HCSA coverage for up to 18 months as long as you give Citigroup notice (with certain exceptions) of the leave. However, this continued coverage may not be available if your total leave, when added to any prior periods of military leave from Citigroup, exceeds five years (with certain exceptions).

If the entire length of the leave is 30 days or less, you won't be required to pay any more than the portion you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the entire amount (both Company and employee contributions).

If you take a military leave — but your coverage under the Plans is terminated, for example, because you don't elect to extend coverage — you'll be treated as if you hadn't taken a military leave upon re-employment when the Plans Administration Committee determines whether an exclusion or waiting period applies once you're reinstated into the Plan.

If you're on a military leave for fewer than 24 months and you don't return to work at the end of your leave, you may be entitled to purchase continuation coverage for medical, dental, vision care, and HCSA coverage for the remaining months, up to a total of 24 months.

Call the Benefits Service Center or contact your HR representative for more information about a military leave.

NOTICE OF HIPAA PRIVACY PRACTICES

This Notice of Privacy Practices describes how the Citigroup Medical Plan, Citigroup Dental Plan, Citigroup Vision Care Plan, and HCSA (collectively referred to in this section as an "Organized Health Care Arrangement" and each individually referred to in this section as a "Component Plan"), may use and disclose your protected health information.

This notice also sets out Component Plans' legal obligations concerning your protected health information and describes your rights to access and control your protected health information. The Component Plans have all agreed to abide by the terms of this notice. This notice has been drafted in accordance with the HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule, contained in the Code of Federal Regulations at 45 CFR Parts 160 and 164. Terms that aren't defined in this notice have the same meaning as they have in the HIPAA Privacy Rule.

For answers to your questions and for additional information. If you have any questions or want additional information about this notice, contact Citigroup as instructed on page 81. To exercise any of the rights described in this notice, contact the third-party administrator for the relevant Component Plan as instructed on page 81.

COMPONENT PLANS' RESPONSIBILITIES

Each Component Plan is required by law to maintain the privacy of your protected health information. The HIPAA Privacy Rule defines "protected health information" to include any individually identifiable health information (1) that's created or received by a health care provider, health plan, insurance company, or health care clearinghouse; (2) that relates to the past, present, or future physical or mental health or condition of such individual; the provision of health care to such individual; or payment for such provision of health care; and (3) that's in the possession or control of an entity covered by the HIPAA Privacy Rule (called "covered entities"), including a group health plan.

Component Plans are obligated to provide you with a copy of this notice setting forth their legal duties and privacy practices regarding your protected health information. Component Plans must abide by the terms of this notice.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The following describes when any Component Plan is permitted or required to use or disclose your protected health information. This list is mandated by the HIPAA Privacy Rule.

Payment and health care operations

Each Component Plan has the right to use and disclose your protected health information for all activities that are included within the definitions of "payment" and "health care operations" as defined in the HIPAA Privacy Rule.

- **Payment.** Component Plans will use or disclose your protected health information to fulfill their responsibilities for coverage and provide benefits as established under their governing documents. For example, Component Plans may disclose your protected health information when a provider requests information about your eligibility for benefits under a Component Plan, or it may use your information to determine if a treatment that you received was medically necessary.
- **Health care operations.** Component Plans will use or disclose your protected health information to fulfill Component Plans' business functions. These functions include, but aren't limited to, quality assessment and improvement, reviewing provider performance, licensing, business planning, and business development. For example, a Component Plan may use or disclose your protected health information (1) to provide you with information about a disease management program; (2) to respond to a customer service inquiry from you; (3) in connection with fraud and abuse detection and compliance programs; or (4) to survey you concerning how effectively such Component Plan is providing services, among other issues.

Business associates. Each Component Plan may enter into contracts with service providers — called business associates — to perform various functions on its behalf. For example, Component Plans may contract with a service provider to perform the administrative functions necessary to pay your medical claims. To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information but only after such Component Plan and the business associate agree in writing to contract terms requiring the business associate to appropriately safeguard your information.

Organized health care arrangement. Component Plans may share your protected health information with each other to carry out payment and health care activities.

Other covered entities. Component Plans may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with certain health care operations. For example, Component Plans may disclose your protected health information to a health care provider when needed by the provider to render treatment to you. Component Plans may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities or accreditation, certification, licensing, or credentialing.

Component Plans also may disclose or share your protected health information with other health care programs or insurance carriers (including, for example, Medicare or a private insurance carrier, etc.) to coordinate benefits if you or your family members have other health insurance or coverage.

Required by law. Component Plans may use or disclose your protected health information to the extent required by federal, state, or local law.

Public health activities. Each Component Plan may use or disclose your protected health information for public health activities permitted or required by law. For example, each Component Plan may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or it may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. Component Plans also may disclose protected health information, if directed by a public health authority, to a foreign government agency collaborating with the public health authority.

Health oversight activities. Component Plans may disclose your protected health information to a health oversight agency for activities authorized by law. For example, these oversight activities may include audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and government agencies that ensure compliance with civil rights laws.

Lawsuits and other legal proceedings. Component Plans may disclose your protected health information in the course of any judicial or administrative proceeding or in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized in the court order). If certain conditions are met, Component Plans also may disclose your protected health information in response to a subpoena, a discovery request, or other lawful process.

Abuse or neglect. Component Plans may disclose your protected health information to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, if a Component Plan believes you've been a victim of abuse, neglect, or domestic violence, it may disclose your protected health information to a government entity authorized to receive such information.

Law enforcement. Under certain conditions, Component Plans also may disclose your protected health information to law enforcement officials for law enforcement purposes. These law enforcement purposes include, for example, (1) responding to a court order or similar process; (2) as necessary to locate or identify a suspect, fugitive, material witness, or missing person; or (3) as relating to the victim of a crime.

Coroners, medical examiners, and funeral directors. Component Plans may disclose protected health information to a coroner or medical examiner when necessary to identify a deceased person or determine a cause of death. Component Plans also may disclose protected health information to funeral directors as necessary to carry out their duties.

Organ and tissue donation. Component Plans may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

Research. Component Plans may disclose your protected health information to researchers when (1) their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information or (2) the research involves a limited data set that includes no unique identifiers, such as name, address, Social Security number, etc.

To prevent a serious threat to health or safety. Consistent with applicable laws, Component Plans may disclose your protected health information if disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. Component Plans also may disclose protected health information if it's necessary for law enforcement authorities to identify or apprehend an individual.

Military. Under certain conditions, Component Plans may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you're a member of foreign military service, Component Plans may disclose, in certain circumstances, your information to the foreign military authority.

National security and protective services. Component Plans may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities and for the protection of the President, other authorized persons, or heads of state.

Inmates. If you're an inmate of a correctional institution or under the custody of a law enforcement official, Component Plans may disclose your protected health information to the correctional institution or to a law enforcement official for (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

Workers' Compensation. Component Plans may disclose your protected health information to comply with Workers' Compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Disclosures to the plan sponsor. Component Plans (or their respective health insurance issuers or HMOs) may disclose your protected health information to Citigroup and its employees and representatives in the capacity of the sponsor of the Component Plans.

Others involved in your health care. Component Plans may disclose your protected health information to a friend or family member involved in your health care, unless you object or request a restriction (in accordance with the process described under "Right to request a restriction" on page 79). Component Plans also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you're not present or able to agree to these disclosures of your protected health information, then, using professional judgment, Component Plans may determine whether the disclosure is in your best interest.

Disclosures to the Secretary of the U.S. Department of Health and Human Services. Each Component Plan is required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining a Component Plan's compliance with the HIPAA Privacy Rule.

Disclosures to you. Each Component Plan is required to disclose to you or to your personal representative most of your protected health information when you request access to this information. Component Plans will disclose your protected health information to an individual who's been designated by you as your personal representative and who's qualified for such designation in accordance with relevant law.

Prior to such a disclosure, however, each Component Plan must be given written documentation that supports and establishes the basis for the personal representation. A Component Plan may elect not to treat the person as your personal representative if it has a reasonable belief that you've been, or may be, subjected to domestic violence, abuse, or neglect by such person; treating such person as your personal representative could endanger you; or such Component Plan determines, in the exercise of its professional judgment, that it isn't in your best interest to treat the person as your personal representative.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Other uses and disclosures of your protected health information that aren't described above will be made only with your written authorization as provided to each Component Plan. If you provide such authorization to a Component Plan, you may revoke the authorization in writing, and such revocation will be effective for future uses and disclosures of protected health information upon receipt. However, the revocation won't be effective for information that such Component Plan has used or disclosed in reliance on the authorization.

CONTACTING YOU

Each Component Plan (or its health insurance issuers, HMOs, or third-party administrators) may contact you about treatment alternatives or other health benefits or services that might be of interest to you.

YOUR RIGHTS

The following is a description of your rights regarding your protected health information. If you wish to exercise any of these rights, you must contact the third-party administrator of the Component Plan that you wish to have comply with your request using the contact information on page 81.

Right to request a restriction. You have the right to request a restriction on the protected health information that a Component Plan uses or discloses about you for payment or health care operations. You also have a right to request a limit on disclosures of your protected health information to family members or friends involved in your care or the payment for your care.

You may request such a restriction using the contact information on page 81. A Component Plan isn't required to agree to any restriction that you request. If a Component Plan agrees to the restriction, it can stop complying with the restriction upon providing notice to you. Your request must include the protected health information you wish to limit; whether you want to limit such Component Plan's use, disclosure, or both; and (if applicable) to whom you want the limitations to apply (for example, disclosures to your spouse).

Right to request confidential communications. If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that a Component Plan communicate with you in an alternative manner or at an alternative location. For example, you may ask that all communications be sent to your work address. You may request a confidential communication using the contact information on page 81.

Your request must specify the alternative means or location for communicating with you. It also must state that the disclosure of all or part of the protected health information in a manner inconsistent with your instructions would put you in danger. A Component Plan will accommodate a request for confidential communications that's reasonable and states that the disclosure of all or part of your protected health information could endanger you.

Right to request access. You have the right to inspect and copy protected health information that may be used to make decisions about your benefits. You must submit your request in writing. If you request copies, the relevant Component Plan may charge you for photocopying your protected health information, and, if you request that copies be mailed to you, for postage. The third-party administrators of the Component Plans have indicated that they don't currently intend to charge for this service, although they reserve the right to do so.

Note: Under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some, but not all, circumstances, you may have a right to have this decision reviewed.

Right to request an amendment. You have the right to request an amendment of your protected health information held by a Component Plan if you believe that information is incorrect or incomplete. If you request an amendment of your protected health information, your request must be submitted in writing using the contact information on page 81 and must set forth a reason(s) in support of the proposed amendment. In certain cases, a Component Plan may deny your request for an amendment.

For example, a Component Plan may deny your request if the information you want to amend is accurate and complete or wasn't created by such Component Plan. If a Component Plan denies your request, you have the right to file a statement of disagreement. Your statement of disagreement will be linked with the disputed information, and all future disclosures of the disputed information by such Component Plan will include your statement.

Right to request an accounting. You have the right to request an accounting of certain disclosures Component Plans have made of your protected health information. You may request an accounting using the contact information on page 81. You can request an accounting of disclosures made up to six years prior to the date of your request, except that Component Plans aren't required to account for disclosures made prior to April 14, 2003.

You're entitled to one accounting from each Component Plan free of charge during a 12-month period. There may be a charge to cover a Component Plan's costs for any additional requests within that 12-month period. Component Plans will notify you of the cost involved, and you may choose to withdraw or modify your request before any costs are incurred.

Right to a paper copy of this notice. You have the right to a paper copy of this notice, even if you've agreed to accept this notice electronically. To obtain such a copy, see the contact information on page 81.

COMPLAINTS

If you believe a Component Plan has violated your privacy rights, you may complain to such Component Plan or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with such Component Plan using the contact information on page 81. Component Plans won't penalize you for filing a complaint.

CHANGES TO THIS NOTICE

Component Plans reserve the right to change the provisions of this notice and to make the new provisions effective for all protected health information that they maintain. If a Component Plan makes a material change to this notice, it'll provide a revised notice to you at the address that it has on record for the participant enrolled with such Component Plan (or, if you agreed to receive revised notices electronically, at the e-mail address you provided to such Component Plan).

EFFECTIVE DATE

This Notice of HIPAA Privacy Practices became effective April 14, 2003.

CONTACT INFORMATION

For more information about any of the rights in this notice, or to file a complaint, contact:

Citigroup Privacy Officer
c/o Corporate Benefits Department
125 Broad St., 8th Floor
New York, NY 10004.

To exercise any of the rights described in this notice, contact the third-party administrators for the Component Plans as follows:

If you're enrolled in any of these Plans:	Call:
• Citigroup Medical Plan **Note:** If you're enrolled in an HMO, call your HMO directly. • Citigroup Dental Plan • Citigroup Vision Care Plan • Health Care Spending Account	ConnectOne at 1-800-881-3938. From the main menu, choose the "health and welfare benefits" option and then follow the prompts to speak with a representative. **From outside the United States** Call 972-652-4582.

COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), requires that most employers sponsoring group health plans offer to employees and eligible dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances (called "qualifying events") where coverage under the plan would otherwise end.

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of the law.

You don't have to show that you're insurable to elect continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. *Citigroup reserves the right to terminate your coverage retroactively if you're determined to be ineligible under the terms of the Plan.*

You must pay the entire contribution plus a 2% administrative fee for your continuation coverage. A grace period of at least 30 days applies to the payment of the regularly scheduled contribution. A 45-day grace period applies to your first payment.

WHO'S COVERED

You have a right to choose this continuation coverage if:

- You're enrolled in Citigroup medical, dental, vision, or HCSA coverage and
- You lose your group health coverage because of a reduction in your hours of employment or the termination of your employment for reasons other than gross misconduct on your part.

If you terminate employment following a leave of absence qualifying under the FMLA, the qualifying event that will trigger continuation coverage will be deemed to occur on the earlier of the date that you indicate you won't be returning to work following the leave or the last day of the FMLA leave period.

If you're the spouse of an employee and are covered by a Citigroup-sponsored medical, dental, or vision Plan (or your claims can be reimbursed through your spouse's HCSA) and you lose coverage under a Citigroup-sponsored group health Plan for any of the following four reasons on the day before the qualifying event, you're a qualified beneficiary and have the right to elect continuation coverage for yourself:

1. The death of your spouse;
2. The termination of your spouse's employment (for reasons other than your spouse's gross misconduct) or a reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse; or
4. Your spouse's entitlement to Medicare.

If you're a covered dependent child of an employee covered by a Citigroup-sponsored medical, dental, or vision Plan or HCSA on the day before the qualifying event and you lose coverage under a Citigroup-sponsored group health Plan for any of the following five reasons, you're also a qualified beneficiary and have the right to continuation coverage:

1. The death of the employee;
2. The termination of the employee's employment (for reasons other than the employee's gross misconduct) or a reduction in the employee's hours of employment;
3. The employee's divorce or legal separation;
4. The employee's entitlement to Medicare; or
5. You cease to be a "dependent child" under the Citigroup-sponsored medical, dental, or vision Plan or HCSA.

If the covered employee elects continuation coverage and then has a child (either by birth, adoption, or placement for adoption) during that period of continuation coverage the new child is also eligible to become a qualified beneficiary.

According to the terms of the employer-sponsored group health plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification of the birth or adoption to Citigroup.

If the covered employee fails to notify Citigroup in a timely fashion (according to the terms of the Citigroup-sponsored group health Plans), the covered employee won't be offered the option to elect COBRA coverage for the child. Newly acquired dependents (other than children born to, adopted by, or placed for adoption with the employee) won't be considered qualified beneficiaries but may be added to the employee's continuation coverage.

SEPARATE ELECTIONS

Each qualified beneficiary has an independent election right for COBRA coverage. For example, if there's a choice among types of coverage, each qualified beneficiary who's eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child is entitled to elect continuation coverage even if the covered employee doesn't make that election. Similarly, a spouse or dependent child may elect different coverage from that chosen by the employee.

ELECTING COBRA

To inquire about COBRA coverage, call ConnectOne at 1-800-881-3938. From the main menu, choose the "health and welfare benefits" option and follow the prompts for a Benefits Service Center representative.

Several weeks after your COBRA-qualifying event, you'll automatically receive COBRA election information from ADP, Citigroup's COBRA administrator. Under the law, you must elect continuation coverage within 60 days from the date you'd lost coverage as a result of one of the events described previously, or, if later, 60 days after Citigroup provides notice of your right to elect continuation coverage. An employee or family member who doesn't choose continuation coverage within the time period described above will lose the right to elect continuation coverage.

If you elect continuation coverage, Citigroup is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified, too. "Similarly situated" refers to a current employee or dependent who hasn't had a qualifying event.

Note: Continuation coverage for vision care is administered through Davis Vision.

DURATION OF COBRA

The law requires that you be afforded the opportunity to maintain continuation coverage for a minimum of 18 months if you lose group health coverage because of a termination of employment or a reduction in work hours.

Additional qualifying events (such as a death, divorce, legal separation, or Medicare entitlement) may occur while the continuation coverage is in effect. These events can result in an extension of an 18-month continuation period to 36 months, but in no event will coverage last beyond 36 months from the date of the event that originally made a qualified dependent eligible to elect coverage. You should notify Citigroup if a second qualifying event occurs during your continuation coverage period.

When COBRA medical coverage ends, generally you *can't* convert your coverage to an individual medical policy. However, some HMOs do offer conversion to individual coverage. Contact your HMO directly.

In no event will continuation coverage for the HCSA be available beyond the end of the year in which the qualifying event occurred.

Special rules for disability

The 18 months may be extended to 29 months if the employee or covered family member is determined by the Social Security Administration (SSA) to be disabled (for Social Security disability purposes) at any time during the first 60 days of continuation coverage.

This 11-month extension is available to all family members who are qualified beneficiaries due to termination or reduction in hours of employment, even those who aren't disabled. To benefit from the extension, the qualified beneficiary must inform Citigroup within 60 days of the SSA determination of disability and before the end of the original 18-month continuation coverage period. If, during continued coverage, the SSA determines that the qualified beneficiary is no longer disabled, the individual must inform Citigroup of this redetermination within 30 days of the date it's made, at which time the 11-month extension will end.

If you or a covered family member is disabled and another qualifying event occurs within the 29-month continuation period, then the continuation coverage period is 36 months after the termination of employment or reduction in hours.

Medicare

If you lose coverage (medical, dental, vision, or HCSA) due to your termination of employment or reduction in hours, and subsequently you become entitled to Medicare, your covered family members are entitled to COBRA coverage for a maximum of 36 months from the date your employment terminated or your reduction in hours occurred.

EARLY TERMINATION OF COBRA

The law provides that your continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- Citigroup no longer provides group health coverage to any of its employees;
- The contribution for continuation coverage isn't paid on time (within the applicable grace period);
- A qualified beneficiary becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that doesn't contain any applicable exclusion or limitation for any pre-existing condition of the individual;
- A qualified beneficiary becomes entitled to Medicare after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability, and a final determination is made by the disability carrier that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage can't be terminated.

However, if the other plan's pre-existing condition rule doesn't apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Plan may terminate your COBRA coverage.

COBRA AND FMLA

A leave that qualified under the FMLA doesn't make you eligible for COBRA coverage. However, regardless of whether you lose coverage because of non-payment of premiums during an FMLA leave, if you decide not to return to active employment you're still eligible for COBRA on the last day of the FMLA leave. Your continuation coverage will begin on the earliest of the following:

- When you definitively inform Citigroup that you aren't returning to work at the end of the leave or
- The end of the leave, assuming you don't return to work

For purposes of an FMLA leave, you'll be eligible for COBRA, as described above, only if:

- You or your dependent is covered by the Plan on the day before the leave begins (or you or your dependent becomes covered during the FMLA leave) and
- You don't return to work at the end of the FMLA leave.

YOUR DUTIES

Under the law, the employee or a family member is responsible for informing Citigroup of:

- A divorce or legal separation;
- The loss of a child's dependent status under the medical, dental, or vision Plan or HCSA;
- An additional qualifying event (such as a death, divorce, legal separation, or Medicare entitlement) that occurs during the employee's or family member's initial continuation coverage of 18 (or 29) months;
- A determination by the SSA that the employee or family member was disabled at some time during the first 60 days of an initial continuation coverage of 18 months; or
- A subsequent determination by the SSA that the employee or family member is no longer disabled.

This notice must be provided within 60 days from the date of the divorce, legal separation, a child's loss of dependent status, or an additional qualifying event. In the case of a disability determination, the notice must be provided within 60 days after the SSA's disability determination and before the end of the initial 18-month continuation coverage.

If the employee or a family member fails to provide this notice to Citigroup during this notice period, any individual(s) who loses coverage *won't* be offered the option to elect continuation coverage.

The notice must be in writing and must include the following information: The applicable Plan name, the identity of the covered employee and any qualified beneficiaries, a description of the qualifying event or disability determination, the date on which it occurred, and any related information customarily and consistently requested by the Plan's COBRA administrator. Mail this information to:

Jacksonville Benefits Service Center
P.O. Box 56710
Jacksonville, FL 32241-6710.

When Citigroup is notified that one of these events has happened, Citigroup, in turn, will notify you that you have the right to elect continuation coverage. If you or your family member fails to notify Citigroup and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce, legal separation, or a child's loss of dependent status, then you and your family members must reimburse the Plans for any claims mistakenly paid.

CITIGROUP'S DUTIES

If any of the following events results in a loss of coverage, qualified beneficiaries will be notified of the right to elect continuation coverage automatically (without any action required by the employee or a family member):

- The employee's death or termination of employment (for reasons other than gross misconduct);
- A reduction in the employee's hours of employment; or
- The employee's entitlement to Medicare.

COST OF COVERAGE

Under the law, you may be required to pay up to 102% of the premium for your continuation coverage. If your coverage is extended from 18 to 29 months for disability, you may be required to pay up to 150% of the premium beginning with the 19th month of continuation coverage.

The cost of group health coverage periodically changes. If you elect continuation coverage, Citigroup will notify you of any changes in the cost. If coverage under the Plan is modified for similarly situated non-COBRA beneficiaries, the coverage made available to you may be modified in the same way.

The initial payment for continuation coverage is due 45 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis for which you have a grace period of at least 30 days.

If you have any questions about COBRA coverage or the application of the law, contact the COBRA administrator at the address below. If your marital status has changed or you or a qualified beneficiary has changed addresses or a dependent ceases to be a dependent eligible for coverage under the terms of the Plan, you must notify the COBRA administrator in writing immediately at the address below.

All notices and other communications regarding COBRA and the Citigroup-sponsored group health Plan should be directed to:

ADP COBRA Services
P.O. Box 27478
Salt Lake City, UT 84127-0478.

You also may call the COBRA administrator at 1-800-422-7608

RECOVERY PROVISIONS

Recovery provisions apply to the Citigroup Medical Plan and Dental Plan and are described in this section.

REFUND OF OVERPAYMENTS

Whenever payments have been made by the Plan for covered or non-covered expenses in a total amount, at any time, in excess of the maximum amount payable under the Plan's provision, the covered person(s) must refund to the Plan the amount paid in excess of the amount payable under the Plan and help the Plan obtain the refund from another person or organization.

If the covered person(s) or any other person or organization that was paid doesn't promptly refund the full amount, the Plan may reduce the amount of any future benefits. The reductions will equal the amount the Plan should have paid. In the case of recovery from a source other than the Plan, the refund equals the amount of recovery up to the amount paid under the Plan. The Plan may have other rights in addition to the right to reduce future benefits.

REIMBURSEMENT

This section applies when a covered person recovers damages — by settlement, verdict, or otherwise — for an injury, sickness, or other condition. If the covered person has made — or in the future may make — such a recovery, including a recovery from an insurance carrier, the Plan won't cover either the reasonable value of the services to treat such an injury or illness or the treatment of such an injury or illness.

However, if the Plan does pay for or provide benefits for such an injury, sickness, or other condition, the covered person — or the legal representatives, estate, or heirs of the covered person — will promptly reimburse the Plan from all recovery amounts (whether or not characterized as related to medical expenses) from any settlement, verdict, or insurance proceeds received by the covered person (or by the legal representatives, estate, or heirs of the covered person) to the extent that medical benefits have been paid for or provided by the Plan to the covered person.

If the covered person receives payment from a third party or his or her insurance company as a result of an injury or harm due to the conduct of another party and the covered person has received benefits from the Plan, the Plan must be reimbursed first. In other words, the covered person's recovery from a third party may not compensate the covered person fully for all of the financial expenses incurred because acceptance of benefits from the Plan constitutes an agreement to reimburse the Plan for any benefits the covered person receives.

The covered person also must take any reasonably necessary action to protect the Plan's subrogation and reimbursement right. That means by accepting benefits from the Plan, the covered person agrees to notify the Plan Administrator if and when the covered person institutes a lawsuit or other action or enters into settlement negotiations with another party (including his or her insurance company) in connection with or related to the conduct of another party.

The covered person also must cooperate with the Plan Administrator's reasonable requests concerning the Plan's subrogation and reimbursement rights and must keep the Plan Administrator informed of any important developments in his or her action. The covered person also

agrees that the Plan Administrator may withhold any future benefits paid by this Plan or any other disability or health plan maintained by Citigroup or its participating companies to the extent necessary to reimburse this Plan under the Plan's subrogation or reimbursement rights.

To secure the rights of the Plan under this section, the covered person hereby:

- Grants to the Plan a first-priority lien against the proceeds of any such settlement, verdict, or other amounts received by the covered person to the extent of all benefits provided in an effort to make the Plan whole;
- Assigns to the Plan any benefits the covered person may have under any automobile policy or other coverage; the covered person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such lien or to effect such assignment of benefits; and
- Will cooperate with the Plan and its agents and will:
  - Sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement;
  - Provide any relevant information; and
  - Take such actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery of the value of the benefits provided.

If the covered person doesn't sign and deliver any such documents for any reason (including, but not limited to, the fact that the covered person wasn't given an agreement to sign or is unable or refuses to sign), the Plan Administrator, in its sole discretion, may or may not advance benefits to the covered person under the Plan.

If the Plan Administrator has advanced benefits, it has the right to subrogation and reimbursement whether or not the covered person has signed the agreement. The covered person shall not take any action that prejudices the Plan's right of reimbursement.

SUBROGATION

This section applies when another party is, or may be considered, liable for a covered person's injury, sickness, or other condition (including insurance carriers that are so liable) and the Plan has provided or paid for benefits.

The Plan is subrogated to all the rights of the covered person against any party, including any insurance carrier, liable for the covered person's injury or illness or for the payment for the medical treatment of such injury or occupational illness to the extent of the value of the medical benefits provided to the covered person under the Plan. The Plan may assert this right independently of the covered person.

The covered person is obligated to cooperate with the Plan and its agents to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with relevant information requested by them; signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim; and obtaining the consent of the Plan or its agents before releasing any party from liability for payment.

If the covered person enters into litigation or settlement negotiations regarding the obligations of other parties, the covered person mustn't prejudice, in any way, the subrogation rights of the Plan under this section.

The costs of legal representation retained by the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation retained by the covered person shall be borne solely by the covered person.

CLAIMS AND APPEALS

If you don't receive a benefit to which you believe you're entitled under any Citigroup Health and Welfare Plan that's subject to ERISA (which excludes Optional GUL/Supplemental AD&D insurance, DCSA, and TRIP), or if your application for benefits is denied, in whole or in part, you may file a claim with the Plan Administrator or Claims Administrator, as applicable. For more information about the Plan Administrator and Claims Administrator, see pages 90-93.

If your claim is denied, you'll receive an explanation in writing detailing:

- The specific reasons for the denial;
- The specific references in the Plan documentation that support these reasons;
- The additional information you must provide to improve your claim and the reasons why that information is necessary; and
- The procedure available for a further review of your claim.

The Plan Administrator or Claims Administrator is generally required to evaluate your claim and notify you of its decision within a specified time period in accordance with ERISA. If your written claim is denied, you have a right to appeal the claim denied by the Plan Administrator or Claims Administrator by filing a request for review of your claim denial. If you wish to bring legal action against the Company or the Plan, you must first go through the Plan's appeals procedures.

The procedures governing claims for benefits, applicable time limits, and remedies available under the applicable Plan for the redress of claims that are denied are included in the Plan document, which is available at **http://www.benefitsbookonline.com**.

You also can call the Plan Administrator to request a copy of the Plan document without charge.

FOR ENROLLMENT-RELATED CLAIMS ONLY

If your application to enroll in the Medical Plan, Dental Plan, or LTD Plan is denied, you may file a claim with the Plans Administration Committee. You may also file an appeal if your claim is denied by the Plans Administration Committee. To file an enrollment-related claim and for information on the claim review process, use the Health and Disability Benefits Eligibility Claims and Appeals Form available to you at no cost through the Benefits Service Center.

Follow the instructions on the form and return the form to the Plans Administration Committee at the address on the form.

ERISA INFORMATION

As a participant in Citigroup Health and Welfare Plans subject to ERISA (which excludes Optional GUL/Supplemental AD&D insurance, DCSA, and TRIP), you have rights under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

You may examine all Plan documents (including group insurance policies, where applicable) and copies of all documents filed with the U.S. Department of Labor (and available at the Public Disclosure Room of the Employee Benefits Security Administration) such as annual reports (Form 5500 Series) and Plan descriptions. You can review these documents at no cost to you at the location of the Plan sponsor.

You may obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may charge a reasonable fee for copying the documents. You may receive a copy of the Plan's annual financial reports upon written request to the Plans Administration Committee.

If there's a loss of coverage under the Plan as a result of a qualifying event, you may continue health care coverage for yourself, spouse, or eligible dependents. You or your dependents may have to pay for such coverage. Review this SPD and all other documents governing the Plan for the rules governing your continuation coverage rights.

You can reduce or eliminate an exclusionary period of coverage for pre-existing conditions under your group health Plan (if one exists), if you have creditable coverage from another plan.

You should be provided a Certificate of Creditable Coverage, free of charge, from your group health Plan or health insurance issuer:

- When you lose coverage under the Plan,
- When your continuation coverage ceases, if you request it before losing coverage; or
- If you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for plan participants, ERISA imposes obligations on plan fiduciaries, the people responsible for the operation of an employee benefit plan. Under ERISA, fiduciaries must act prudently and solely in the interest of participants and their beneficiaries. No one, including your employer or any other person, may fire you or discriminate in any way against you to prevent you from obtaining a welfare benefit or for exercising your rights under ERISA.

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. For more information see the "Claims and appeals" section on page 87.

Under ERISA, you can take steps to enforce the rights described above. For example, if you request materials from the Plan and don't receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive them, unless the materials weren't sent for reasons beyond the Plan Administrator's control.

If your claim for benefits is denied or ignored, in full or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a Qualified Medical Child Support Order, you may file suit in federal court. If you believe the fiduciaries are misusing their authority under the Plan or if you believe you're being discriminated against for asserting your rights, you may request assistance from the U.S. Department of Labor or file a suit in federal court.

The court will decide who should pay court costs and legal fees. If your suit is successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. One instance in which you may be required to pay court costs and legal fees is if the court finds your suit to be frivolous.

ANSWERS TO YOUR QUESTIONS

If you have questions about the Plan, contact the Plan Administrator.

If you have any questions about this book or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constutution Ave. NW, Washington, DC 20210.

The Employee Benefits Security Administration's New York City branch is located at 1633 Broadway, Room 226, New York, NY 10019.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications' hotline of the Employee Benefits Security Administration or by accessing the Web site at **http://www.dol.gov/ebsa**.

ADMINISTRATIVE INFORMATION

This section contains a statement about the future of the Plans and Citigroup's right to amend, modify, suspend, or terminate the Plans as well as general information about the administration of the Citigroup Plans, Plan documents, sponsors, and Claims Administrators.

FUTURE OF THE PLANS

The Plans are subject to various legal requirements. If changes are required for continued compliance, you'll be notified.

Citigroup has the right to amend, modify, suspend, or terminate any Plan, in whole or in part, at any time without prior notice. Citigroup may make any such amendment, modification, suspension, or termination of the Plans.

In the event of the dissolution, merger, consolidation, or reorganization of Citigroup, the Plan will terminate unless the Plan is continued by a successor to Citigroup. If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to Citigroup to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document.

PLAN ADMINISTRATION

The Plan Administrator is responsible for the general administration of the Plans and has the full discretionary authority and power to control and manage all the administrative aspects of the Plans, except to the extent such authority has been delegated to the Claims Administrator.

In accordance with such delegation, the Plan Administrator and the Claims Administrator have the full discretionary authority to construe and interpret the provisions of the Plans and make factual determinations regarding all aspects of the Plans and their benefits including the power and discretion to determine the rights or eligibility of employees and any other persons and the amounts of their benefits under the Plan and to remedy ambiguities, inconsistencies, or omissions. Such determinations shall be binding on all parties.

The Plan has designated other organizations or persons to act out specific fiduciary responsibilities in administering the Plan including, but not limited to, any or all of the following responsibilities:

- To administer and manage the Plan, including the processing and payment of claims under the Plan and the related recordkeeping, according to the terms of an administrative services or claims administration agreement;
- To prepare, report, file, and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan; and
- To act as Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator isn't empowered with such responsibility.

The Plan Administrator will administer the Plan on a reasonable and non-discriminatory basis and shall apply uniform rules to all persons similarly situated. Except to the extent superseded by laws of the United States, the laws of New York will control in all matters relating to the Plan.

PLAN INFORMATION

PLAN SPONSOR	Citigroup Inc. 75 Holly Hill Lane Greenwich, CT 06830
EMPLOYER IDENTIFICATION NUMBER	52-1568099
PLAN ADMINISTRATOR	Plans Administration Committee of Citigroup Inc. 125 Broad St., 8th Floor New York, NY 1004
PLAN NAMES AND NUMBERS	
Medical Plan (self-funded ChoicePlan, Health Plan 2000, Hawaii Health Plan, Out-of-Area Plan, and HMOs) including prescription drugs	Citigroup Health Benefit Plan, Plan #508
Dental Plan	Citigroup Dental Benefit Plan, Plan #505
Vision Care Plan	Citigroup Vision Benefit Plan
Health Care Spending Account Dependent Care Spending Account	Citigroup Flexible Benefits Plan, Plan #512
Transportation Reimbursement Incentive Program	Citigroup Transportation Reimbursement Incentive Program
Basic Life insurance/AD&D Optional GUL/Supplemental AD&D Business Travel Accident insurance Citigroup Long-Term Care insurance	Citigroup Life Insurance Benefits, Plan #506 Not applicable Citigroup Life Insurance Benefits, Plan #510 Citigroup Long-Term Care Insurance, Plan #535
Short-Term Disability	Citigroup Salary Continuation (Short-Term Disability) Plan, Plan #529
Long-Term Disability	Citigroup Long-Term Disability (LTD) Plan, Plan #530

CLAIMS ADMINISTRATORS

Each of the Claims Administrators below has the discretion and authority to render benefit determinations in a manner consistent with the terms and conditions of its respective benefit Plan, namely, those provisions of the Plan document that apply to the participant and administered by that particular Claims Administrator. Since TRIP, DCSA, and Optional GUL/Supplemental AD&D aren't subject to ERISA, neither the Claims Administrator listed below nor the Plans Administration Committee is a fiduciary under ERISA for these arrangements.

MEDICAL PLAN AND PRESCRIPTION DRUG COVERAGE	
ChoicePlan and Health Plan 2000	Aetna Citigroup Claims Division P.O. Box 981106 El Paso, TX 79998-1106 1-800-545-5862 CIGNA HealthCare P.O. Box 5200 Scranton, PA 18505-5200 1-800-794-4953 or P.O. Box 182223 Chattanooga, TN 37422-7223 Empire BlueCross BlueShield* P.O. Box 5072 Middletown, NY 10940-9072 1-866-290-9098 UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 1-877-311-7845
For fully insured HMOs	Call the Citigroup HMO Administrator at 1-800-422-6106.
For self-insured HMOs	Aetna P.O. Box 981107 El Paso, TX 79998-1107 1-800-821-3808 CIGNA HealthCare P.O. Box 5200 Scranton, PA 18505-5200 1-800-794-4953 or P.O. Box 182223 Chattanooga, TN 37422-7223

*Empire BlueCross BlueShield is a trademark of Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. Empire doesn't underwrite or assume any financial risk for claims liability.

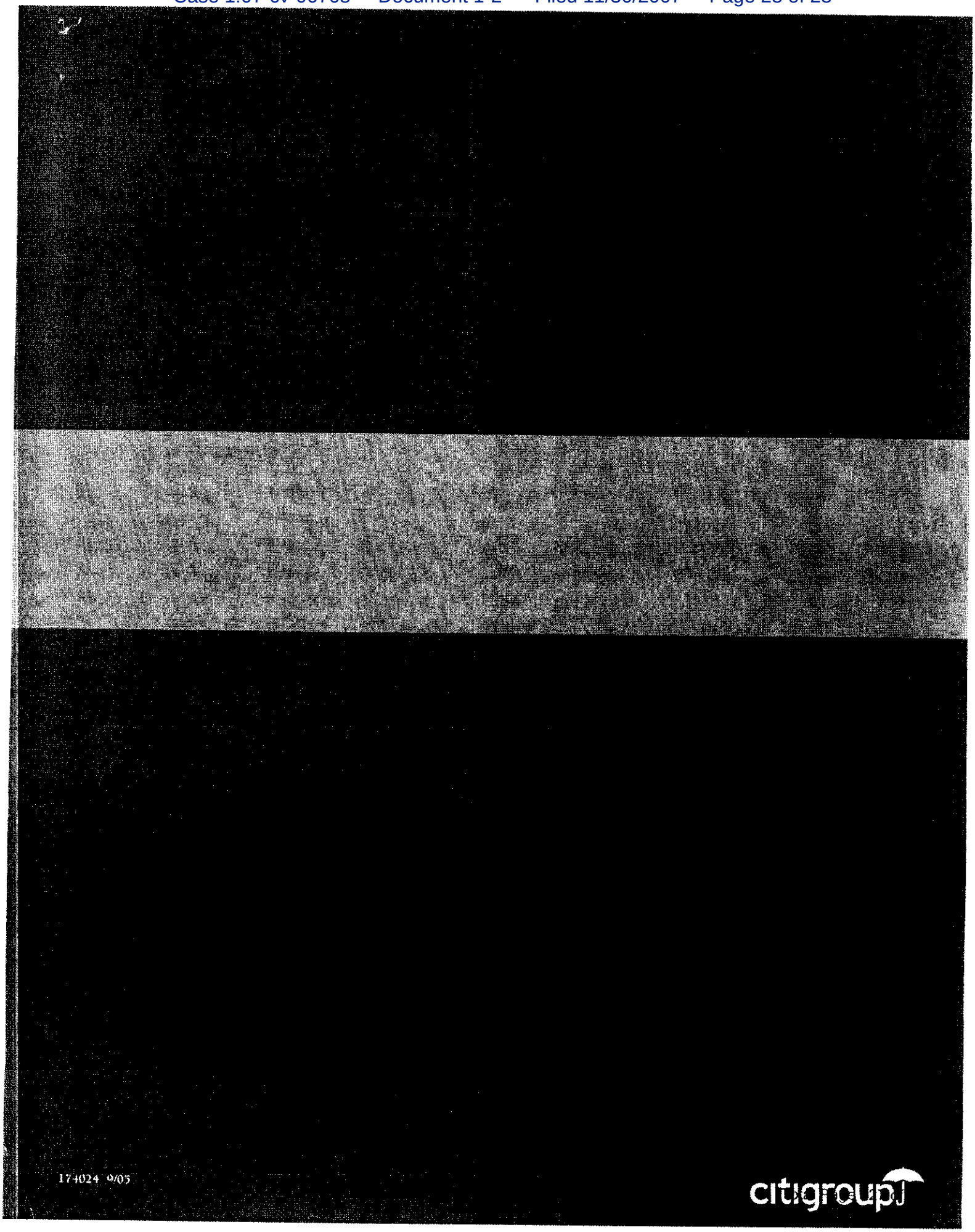
For self-insured HMOs (cont'd.)	UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 1-877-311-7845 UnitedHealthcare – Medica Self-Insured P.O. Box 659752 San Antonio, TX 78265-9752 1-877-311-7845 Empire BlueCross BlueShield P.O. Box 5072 Middletown, NY 10940-9072 1-866-290-9098
Hawaii Health Plan	UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 1-877-311-7845
Out-of-Area Health Plan	Empire BlueCross BlueShield P.O. Box 5072 Middletown, NY 10940-9072 1-866-290-9098
Prescription Drug Program (paper claims address) (home delivery service)	Express Scripts Pharmacy P.O. Box 66583 St. Louis, MO 63166 Express Scripts Pharmacy Home Delivery Service P.O. Box 510 Bensalem, PA 19020-0510
DENTAL PLAN	
MetLife Preferred Dentist Program	Metropolitan Life Insurance Co. MetLife Dental Claims Unit P.O. Box 14093 Lexington, KY 40512-4093 1-888-832-2576
CIGNA Dental Care DHMO	CIGNA Dental/Member Services Suite 700 300 NW 82nd Ave. Plantation, FL 33324 1-800-367-1037

Delta Dental	Delta Dental One Delta Drive Mechanicsburg, PA 17055 1-877-248-4764
VISION	
Vision Care Plan	Davis Vision 159 Express St. Plainview, NY 11803 516-932-9500 1-800-DAVIS-2-U
SPENDING ACCOUNTS	
Health Care Spending Account (HCSA) Dependent Care Spending Account (DCSA) Transportation Reimbursement Incentive Program (TRIP)	ADP Claims Processing Center P.O. Box 1800 Alpharetta, GA 30023-1800 1-800-378-1823 Fax: 678-762-5693
LIFE INSURANCE	
Basic Life	Metropolitan Life Insurance Co. One Madison Ave. New York, NY 10010 1-800-638-6420
Optional Life	Metropolitan Life Insurance Co. One Madison Ave. New York, NY 10010 1-800-638-6420
AD&D and Supplemental AD&D	Life Insurance Company of North America (CIGNA) 1601 Chestnut St. Philadelphia, PA 19192 215-761-1000
Business Travel Accident	Life Insurance Company of North America (CIGNA) 1601 Chestnut St. Philadelphia, PA 19192 215-761-1000

LONG-TERM DISABILITY	
	Metropolitan Life Insurance Co. P.O. Box 14590 Lexington, KY 40511-4590 1-888-830-7380
LONG-TERM CARE	
	John Hancock Life Insurance Co. Group Long-Term Care, Floor X-3 529 Main St. Charlestown, MA 02129
AGENT FOR SERVICE OF LEGAL PROCESS	
	Citigroup Inc. General Counsel 399 Park Ave., 3rd Floor New York, NY 10043
PLAN YEAR	January 1-December 31
FUNDING	
Medical Plan Dental Plan Vision Care Plan Health Care Spending Account (HCSA) Dependent Care Spending Account (DCSA) Transportation Reimbursement Incentive Program (TRIP)	The Medical Plan, Dental Plan, HCSA, DCSA, and TRIP (with the exception of the Vision Care Plan, the CIGNA DHMO, and the many fully insured HMOs) are paid from the general assets of Citigroup and may be paid from a trust qualified under section 501(c)(9) of the IRC on behalf of the Plans in accordance with the terms of their Plan documents. The Vision Care Plan, CIGNA DHMO, and the fully insured HMOs are funded through an insurance contract. The cost of medical and dental coverage is shared by Citigroup and the participant. The cost of the Vision Care Plan, HCSA, DCSA, and TRIP is provided by employee contributions. Citigroup subsidizes the DCSA contribution for eligible employees. The Claims Administrators don't guarantee benefits under the Plan.

Basic Life/AD&D insurance Optional GUL/Supplemental AD&D insurance Business Travel Accident insurance	The Basic Life/AD&D, Optional GUL/Supplemental AD&D, and Business Travel Accident insurance are fully insured. Benefits are provided under insurance contracts between Citigroup and the Claims Administrator. The Claims Administrator, not Citigroup, is responsible for paying claims. Basic Life/AD&D and Business Travel Accident coverage is provided through employer contributions; Optional GUL/Supplemental AD&D is provided through employee contributions.
Short-Term Disability (STD)	STD benefits are paid from the general assets of the Company and a trust qualified under section 501(c)(9) of the IRC in accordance with the terms of the Plan document. STD coverage is provided by Citigroup, and no employee contributions are required.
Long-Term Disability (LTD)	LTD benefits are fully insured. The Claims Administrator, not Citigroup, is responsible for paying claims. LTD coverage is provided through both employer and employee contributions.
Long-Term Care insurance (LTC)	LTC benefits are fully insured. The cost of LTC coverage is provided by employee contributions
TYPE OF ADMINISTRATION	
	The Plans are administered by the Plans Administration Committee. However, the final decision on the payment of claims under certain Plans rests with the Claims Administrators.

Notice required by the Florida Insurance Department: Some of these Plans are self-insured group health plans not regulated by the Florida Insurance Department. Payment of claims is completely dependent on the financial solvency of the employer or other entity sponsoring the Plans. No guaranty fund exists to cover claims that a bankrupt or otherwise insolvent employer or plan sponsor can't pay.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